Participating Provider Option PPO

BlueCross BlueShield of Illinois

COUNTY OF MCHENRY
07/01/2013

BENEFIT HIGHLIGHTS

PPO Network

This provides only highlights of the benefit plan. After enrollment, members will receive a Certificate that more fully describes the terms of coverage.

Program Basics	PPO (In-Network)	Non-PPO (Out-of-Network)
Lifetime Benefit Maximum		
Per individual	*Unlimited*	
Individual Coverage Deductible		
Program deductible does **not** apply to services that have a copayment.	*$250 ee/ret/dep*	*$425 ee/ret/dep*
Family Coverage Deductible		
Aggregate	*$600 ee/ret/dep*	*$1,125 ee/ret/dep*
Individual Coverage Out-of-Pocket Expense (OPX) Limit		
The amount of money that any individual will have to pay toward covered health care expenses during any one calendar year. The following items will **not** be applied to the out-of-pocket expense limit: • **Deductibles** • **Copayments** • **Reductions in benefits** due to non-compliance with utilization management program requirements • **Charges that exceed the eligible charge** or the Schedule of Maximum Allowances (SMA) • **Services that are asterisked below** (*)	*$1,200*	*$3,200*
Family Coverage Out-of-Pocket Expense (OPX) Limit		
	$2,400	*$7,200*

Physician Services		
Physician Office Visits		
Surgeries, therapies, allergy injections or treatments and certain diagnostic procedures performed in a physician's office may be subject to the deductible and/or coinsurance, including mental health and substance abuse services.	*85% after deductible*	*75% after deductible*
Preventive Care		
Routine annual physicals, well-baby exam, immunizations, and other preventive health services as determined by the USPSTF.	*100%*	*75% after deductible*
Maternity Services		
Copayment applies to first prenatal visit (per pregnancy). All other maternity physician covered services are paid the same as Medical / Surgical Services.	*85% after deductible*	*75% after deductible*
Medical / Surgical Services		
Coverage for surgical procedures, inpatient visits, therapies, allergy injections or treatments, and certain diagnostic procedures as well as other physician services.	*85% after deductible*	*75% after deductible*

Hospital Services		
Hospital Admission Deductible		
Per admission, per individual	*n/a*	*$100*
Inpatient Hospital Services		
Coverage includes services received in a hospital, skilled nursing facility, coordinated home care and hospice, including mental health and substance abuse services. Room allowances based on the hospital's most common semi-private room rates.	*85% after deductible*	*65% after deductible*
Outpatient Hospital Services		
Coverage for services includes, but is not limited to outpatient or ambulatory surgical procedures, x-ray, lab tests, chemotherapy, radiation therapy, renal dialysis, and mammograms performed in a hospital or ambulatory surgical center, including mental health and substance abuse services. Routine mammograms performed in an in-network outpatient hospital setting are payable at 100%, no deductible will apply.	*85% after deductible*	*65% after deductible*
Outpatient Diagnostic Services		
	100% no deductible	*75% after deductible*
Outpatient Emergency Care (Accident or Illness)		
The copayment applies to both in- and out-of-network emergency room visits. The copayment is waived if the member is admitted to the hospital.	*$100 copay, then 80%, no deductible*	

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Additional Services

Retail Prescription Drug Benefit* - Provides up to a 34 day supply. Certain FDA approved women's contraceptive prescriptions are covered at no cost – no copay, no deductible, no coinsurance.	*100% after*	*75% after*
• Generic Drug	*$5 copay*	*$5 copay*
• Brand Formulary Drug	*$25 copay*	*$25 copay*
• Brand Non-Formulary Drug	*$35 copay*	*$35 copay*
• Specialty Drug	*$70 copay*	*$70 copay*
Mail Order Prescription Drug Benefit *- Provides up to a 90 day supply of maintenance drugs– excluding Specialty Drugs - used on a continuous basis. If a brand named drug is obtained when a generic is available, member will be responsible for the brand copay plus the difference in cost.*	*1- ½ times retail copay*	*N/A*
Muscle Manipulation Services*		
Coverage for spinal and muscle manipulation services provided by a physician or chiropractor. Related office visits are paid the same as other Physician Office Visits.	*85% after deductible*	*75% after deductible*
• $3,000 maximum per calendar year.		
Therapy Services – Speech, Occupational and Physical		
Coverage for services provided by a physician or therapist. (Please refer to Certificate for details)	*85% after deductible*	*75% after deductible*
Temporomandibular Joint (TMJ) Dysfunction and Related Disorders	*85% after deductible*	*75% after deductible*
Other Covered Services		
• Private duty nursing – unlimited visits • Naprapathic services* - $1,000 maximum per calendar year • Artificial limbs and other prosthetic devices • Blood and blood components • Ambulance services • Orthotic appliances • Prosthetic appliances • Medical Supplies *See paragraph below regarding Schedule of Maximum Allowances (SMA).*	*80% after deductible*	

* Does not apply to any out-of-pocket limits

Durable Medical Equipment (DME) is a covered benefit. Please refer to Certificate for details.

Optometrists, Orthotic, Prosthetic, Pedorthists, Registered Surgical Assistants, Registered Nurse First Assistants and Registered Surgical Technologists are covered providers. Please refer to Certificate for details.

Discounts on Eye Exams, Prescription Lenses and Eyewear
Members can present their ID cards to receive discounts on eye exams, prescription lenses and eyewear. To locate participating vision providers, log into Blue Access® for Members (BAM) at www.bcbsil.com/member and click on the **BlueExtras Discount Program** link.

Blue Care Connection (BCC)
When members receive covered inpatient hospital services, outpatient mental health and substance abuse services (MHSA), coordinated home care, skilled nursing facility or private duty nursing from a participating provider, the member will be responsible for contacting either the BCC or MHSA preauthorization line, as applicable. You must call one day prior to any hospital admission and/or outpatient MH/SA service or within 2 business days after an emergency medical or maternity admission. Please refer to your benefit booklet for information regarding benefit reductions based on failure to contact the applicable preauthorization line**. Note: Outpatient MHSA preauthorization is effective for services on or after January 1, 2011 or upon your group plan renewal date in 2011 and thereafter.**

Schedule of Maximum Allowances (SMA)
The Schedule of Maximum Allowances (SMA) is not the same as a Usual and Customary fee (U&C). Blue Cross and Blue Shield of Illinois' SMA is the maximum allowable charge for professional services, including but not limited to those listed under Medical/Surgical and Other Covered Services above. The SMA is the amount that professional PPO providers have agreed to accept as payment in full. When members use PPO providers, they avoid any balance billing other than applicable deductible, coinsurance and/or copayment. "*Please refer to your certificate booklet for the definition of Eligible Charge and Maximum Allowance regarding Providers who do not participate in the PPO Network.*".

To Locate a Participating Provider: Visit our Web site at **www.bcbsil.com/providers** and use our Provider Finder® tool.

In addition, benefits for covered individuals who live outside Illinois will meet all extraterritorial requirements of those states, if any, according to the group's funding arrangements.